ENT OF HEALTH AND HUMAN SERVICES
ARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

NSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 5 - 0 0 1

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX

EGIONAL ADMINISTRATOR
EALTH CARE FINANCING ADMINISTRATION
EPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
(p. 10 & 10a)
2/1/95 ; 3/11/95 (p.27)

E OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

ERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 1995 $ 2.1 million
b. FFY 1996 $ 2.1 million

GE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, pages 10, 10a and 27.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, pages 10 and 27 are superseded.

BJECT OF AMENDMENT:
cute Hospital Inpatient Payment System

OVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required under 42 CFR 430.12(b)(2)(i)

GNATURE OF STATE AGENCY OFFICIAL:
Bruce Bullen

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street, 3rd Floor
Boston, MA 02111

YPED NAME:
Bruce Bullen

TLE:
Commissioner, Division of Medical Assistance

ATE SUBMITTED:
3/31/95

FOR REGIONAL OFFICE USE ONLY

ATE RECEIVED:
March 31, 1995

18. DATE APPROVED:
May 11, 2001

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:
pages 10 & 10a (2/1/95; p. 27 (3/11/95)

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis M. Maloney for

YPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO

EMARKS:

FFICIAL

ORM HCFA-179 (07-92)

Instructions on Back

3. ***Calculation of the Pass-through Amount per Discharge***

The pass-through amount per discharge is the sum of the per discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the hospital's inpatient portion of expenses by the number of total, non-psychiatric inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from Medicaid paid claims files for dates of payment for the period June 1, 1993 through May 31, 1994.

The inpatient portion of malpractice costs was derived from the FY91 MAC and updated by applying inflation factors of 3.01% and 2.80%. The inpatient portion of organ acquisition costs was derived from the FY93 Medicare Cost Report (2552).

4. ***Direct Medical Education***

The inpatient portion of direct medical education costs were derived from each hospital's FY93 Medicare cost report (2552). Effective February 1, 1995, for hospitals which began new primary care teaching programs between July 1 and September 30, 1994, and for which the FY93 Medicare cost report does not include these new costs, the Division shall recognize, on an interim basis, (i.e., until such costs appear on cost reports used by the Division) such new costs submitted by the hospital, as are determined to be reasonable by the Division. In testing the costs of new primary care training programs for reasonableness, the Division will compare hospital's stated costs of the new programs to the costs of similar programs at other hospitals in the state. In conducting this comparison, the Division will make allowances for differing circumstances among providers, such as intern/resident class size, input prices (e.g., labor, supplies, capital), and class composition by practice area. To further assess reasonableness of the stated costs, the Division also will examine reported teaching costs for consistency with Division of Health Care Finance and Policy's instructions for the DHCFP-403 cost report. Once those costs appear on the cost report being used by the Division to calculate direct medical education costs, the Division will recognize costs as reported on such cost reports, rather than those costs submitted directly by hospitals to the Division. Such incremental costs for new programs shall be annualized. In each instance, the amount was calculated by dividing the hospital's inpatient portion of expenses by the number of total (non-psychiatric) inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division has incorporated an incentive in favor of primary care training which was factored into the recognized direct medical education costs by weighing costs in favor of primary care training. An incentive of 33% was applied to the per discharge costs of primary care training; a discount of 20% was applied to the per discharge costs of specialty care training. The number of primary care and specialty care trainees was derived from data provided to the Division by the hospitals.

Growth in direct medical education costs attributable to wage inflation will be subjected to a 10% annual limit. An audit may be performed by the Division to verify the appropriateness of reported teaching costs.

MAY 11 2001

Approval Date _____
Effective Date 2/1/95

5. *Capital Payment Amount per Discharge*

The capital payment is a blend of actual capital costs, based on the FY92 Medicare cost report (2552), and a casemix-adjusted capital cost limit, based on the FY91 Medicare cost report (2552), updated for projected inflation, to be phased-in over five years.

For each hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, and long-term and short-term interest. Total capital costs are allocated to inpatient services through the square footage-based allocation formula used in the Medicare cost report (2552). The Medicare cost report is also used to identify capital allocated to distinct part psychiatric units and to subtract this amount from total inpatient capital in order to calculate the (non-DPU) capital cost per discharge.

The capital cost per discharge is calculated by dividing total inpatient capital costs (less

payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; and by 2.80% to reflect inflation between RY94 and RY95.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days. Effective March 11, 1995, for any pediatric hospital (as defined in Section 2) which had a minimum of 2,500 pediatric admissions in rate year 1994, the Division will reimburse outlier days which occur between March 11, 1995 and September 30, 1995 at the hospital's transfer per diem rate.

Acute hospitals which receive payment as specialty hospitals and pediatric units shall be determined by the Division.

3. ***Public Service Hospital Providers***

The standard inpatient payment amount for public service hospital providers (as defined in Section II) shall be equal to the sum of:

> *97% of the hospital's actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY95 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.*

Derivation of actual FY90 Medicaid costs is described in Section IV.2.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's RY95 casemix index. Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.35% to reflect inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; and by 2.80% to reflect inflation between RY94 and RY95.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. ***Essential Neonatal Intensive Care Unit (NICU) Services***

Hospitals with a designated inpatient neonatal intensive care unit, as defined by the Massachusetts Department of Public Health, qualify for the payment amounts described in a. and b. below.

a. ***New Essential NICU Services***

Payment for new essential NICU services, for hospitals that began operating and admitting NICU patients during rate year 1993, shall be made as an add-on to the SPAD rate described in Section IV.2.A.2 The add-on amount shall equal the Medicaid share of reasonable costs of the NICU unit (as submitted to and